STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155620	B. WING		08/24/2012
		_	STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	₹	675 S F	FORD RD	
ZIONSVI	LLE MEADOWS			VILLE, IN 46077	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
K0000					
	A Life Safety C	ode Recertification and	K0000		
	1	Survey was conducted by	Roood	The creation and submission of	of
				this plan of correction does no	
	the Indiana State Department of Health in accordance with 42 CFR 483.70(a).			constitute an admission by this	
				provider of any conclusion set	
	Survey Date: 08	8/24/12		forth in the statement of deficiencies, or of any violation regulation.	n of
	Facility Number	000538			
	Provider Number				
	AIM Number:			This provider respectfully	
	Alivi Number.	100267290		requests that the 2567 plan of	
		a 1 7:0 a 0		correction be considered as th	
	1	Caraher, Life Safety		letter of credible allegation and	d l
	Code Specialist			request a desk review on or a September 23, 2012.	fter
	At this Life Safe	ety Code survey.			
		lows was found not in			
		Requirements for			
	•	Medicare/Medicaid, 42			
	•	3.70(a), Life Safety from			
	_	0 Edition of the National			
		Association (NFPA) 101,			
	1	e (LSC), Chapter 19,			
	_	Care Occupancies and			
	410 IAC 16.2.				
	-	M41, 4 45.4 4			
	1	acility is a split level			
	_	h of the two floors exiting			
	at ground level and was determined to be of Type II (222) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the				
		all areas open to the			
	Corridors und III	an areas open to the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155620		A. BUII B. WIN		DING 01		ETED 2012
NAME OF P	PROVIDER OR SUPPLIER		D. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
	LLE MEADOWS				ORD RD /ILLE, IN 46077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	hard wired to the resident sleeping a capacity of 185 at the time of this Quality Review by I Code Specialist-Med	Robert Booher, Life Safety dical Surveyor on 08/31/12. found not in compliance ntioned regulatory					

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Event ID: W9GJ21

Facility ID: 000538

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	O1 COMP		ETED
		155620	B. WIN	G		08/24/	2012
	PROVIDER OR SUPPLIER			675 S F	ADDRESS, CITY, STATE, ZIP CODE FORD RD VILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0027 SS=E	least a 20-minute at least 1%-inch to core. Non-rated pexceed 48 inches door are permitte comply with 7.2.1 or automatic closs 19.2.2.2.6. Swing to swing with egranot required. The Based on observing facility failed to smoke barrier dosmoke resistant to Medicare & Medicare & Medicare sets of swhich swing in the equipped with an accordinator to error close first, always deficient practices staff and visitors barrier doors by and by the Busing Findings included Based on observing General Manage Assistant during 1:00 p.m. to 4:40 set of smoke barriers.	smoke barriers have at fire protection rating or are hick solid bonded wood protective plates that do not a from the bottom of the d. Horizontal sliding doors .14. Doors are self-closing ing in accordance with ging doors are not required less and positive latching is 9.3.7.5, 19.3.7.6, 19.3.7.7 ation and interview, the ensure 2 of 10 sets of foors would close to form a parrier. Centers for dicaid Services (CMS) moke barrier doors he same direction and are a stragal to have a fisure the door which must be could affect 28 residents in vicinity of the smoke the Cottage 2 elevator less Office.	K00)27	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Door located in cottage two had a new coordinator installed on 8/27/2012 to ensure that fire doors shut in the proper order thus creating a smoke/fire barrier that is necessary to contain a fire. The coordinator on the door by the business office was adjusted to ensure that it works properly allowing the doors to close in the proper order; this was also completed on 8/27/2012 2) How the facility will identify other residents having the potentiat to be affected by the same deficien practice and what corrective action will be taken: All residents have the potential to be affected. An audit of all fire doors within the facility was conducted to ensure all coordinator	a /	09/21/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	INSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
ANDIEM	or conduction	155620		LDING		08/24/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	TR.			ORD RD		
ZIONSVI	LLE MEADOWS			ZIONS\	/ILLE, IN 46077		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPT	LETION TE
		and are equipped with an			functioned properly and all doors		
		oor closing coordinator			closed correctly in ensure the		
	_	ed. The set of smoke			establishment of a smoke/fire		
	barrier doors in	the corridor by the			barrier.		
	Business Office	swing in the same			3) What measures will be put into		
	direction, are ed	quipped with an astragal			place or what systemic changes the	:	
	and a door close	ing coordinator but the			facility will make to ensure that the	•	
	_	ordinator did not function			deficient practice does not recur: All fire doors will be checked during		
		e barrier door set was			the required monthly fire drills and		
		nes leaving a five inch gap			documented that they are		
		ors which is not smoke			functioning properly on the monthly	,	
		d on interview at the time			fire drill form that is documented by	,	
		ions, the Assistant General			the facility Maintenance Director.	(0)	
	_	wledged each smoke			4) How the corrective action will be monitored to ensure t		
		did not close completely			deficient practice will not rec	-	
		or closing coordinator was			i.e. what quality assurance		
	_	or not functioning to			program will be put into plac		
		equipped with an astragal			Facility Administrator or design will ensure that monthly fire dr		
		form a smoke resistant			and documentation accurately		
	barrier.				reflect that fire doors are		
					functioning properly.		
	3.1-19(b)				Administrator or designee will sign off on the fire drill logs to		
					document that they are being		
					monitored		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155620	B. WIN			08/24/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				FORD RD		
ZIONSVI	LLE MEADOWS				VILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0038	NFPA 101						
SS=E	LIFE SAFETY CO						
		anged so that exits are					
	with section 7.1.	e at all times in accordance 19.2.1					
		ation and interview, the	K00	128			09/21/2012
			1200	000	What corrective action(s) will be	,	09/21/2012
	_	ensure the means of			accomplished for those residents	;	
		2 of 8 delayed egress			found to have been affected by the		
		ity was readily accessible			deficient practice: 1 egress door on		
	for residents, sta	ff and visitors. LSC			A wing east that was not		
	7.2.1.6.1, Delaye	ed Egress Locks, says			functioning properly was repaired		
	approved, listed,	delayed egress locks			on 8/27/2012 and now functions		
		d to be installed on doors			properly allowing for magnetic locks	5	
	•	ordinary hazard contents			to automatically release after being		
	_	ected throughout by an			pushed on for 15 seconds. Egress		
	• •	vised automatic fire			door in crystal dining room now has		
					the proper signage stating that door		
		installed in accordance			will automatically unlock after being		
	with Section 9.6.	* *			pushed for 15 seconds, satisfying the	e	
	-	natic sprinkler system			safety code standard.		
		rdance with Section 9.7,			2) How the facility will identify		
	_	tted in Chapters 12			other residents having the potentia	ıl	
	through 42, prov	ided: (c) An irreversible			to be affected by the same deficien		
	process shall rele	ease the lock within 15			practice and what corrective action	ı	
	seconds upon ap	plication of a force to the			will be taken: All residents have the		
	release device re	quired in 7.2.1.5.4 that			potential to be affected. An audit of	f	
		ired to exceed 15 lbf nor			all facility exit doors was conducted		
	-	entinuously applied for			to ensure proper signage is in place		
	•	onds. The initiation of the			and those doors with magnetic locks		
					release when panic bar is held for 15	5	
	-	hall activate an audible			seconds.		
	_	nity of the door. Once			3) What measures will be put into		
		s been released by the			place or what systemic changes the	,	
		rce to the releasing			facility will make to ensure that the		
	device, relocking	g shall be by manual			deficient practice does not recur:	•	
	means only. Exc	ception: Where approved			All exit egress doors will be		
		having jurisdiction, a			monitored monthly on our rolling		
					l '		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED
		155620	B. WIN			08/24/2012
NAME OF F	DROVIDED OD GUDDU IED		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			675 S F	ORD RD	
ZIONSVI	LLE MEADOWS			ZIONS\	/ILLE, IN 46077	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		ling 30 seconds shall be			egress door check form that will be	
	permitted. (d) O	on the door adjacent to the			completed by facility Maintenance	
	release device, the	nere shall be a readily			Director.	
	visible, durable s	sign in letters not less			4) How the corrective action(s) will	
	than 1 inch high and at least 1/8 inch in				be monitored to ensure the	
	stroke width on a contrasting background				deficient practice will not recur, i.e.	.
	that reads:				what quality assurance program	
	PUSH UNTIL A	LARM SOUNDS.			will be put into place. Facility	
	DOOR CAN BE	OPENED IN 15			Administrator or designee will	
	SECONDS				ensure that monthly documentation	1
	This deficient practice could affect 127				accurately reflect that egress doors are functioning properly monthly fo	r
		r visitors wanting to exit			4 months. Administrator or	'
	· ·	the exit by Room 116 in			designee will sign off on the	
		and the Crystal Dining			documentation to ensure that they	
		e service corridor.			are being monitored and properly	
	Koom exit by the	c service corridor.			documented on.	
	Findings include	:				
	Based on observ	ations with the Assistant				
		r and the Maintenance				
		a tour of the facility from				
) p.m. on 08/24/12:				
	_	by Room 116 in the A				
		pped with a delayed				
		h was provided with				
	1 -	he door could be opened				
		pushing on the door				
		-				
	release device, but the exit door did not					
	release within 15 seconds when the door was pushed with the application of force					
	_	es. Based on interview at				
		vation, the Assistant				
	_	r acknowledged the exit				
	door by Room 1	16 in the A East Hall is				

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	155620	A. BUI	LDING	01	COMPL 08/24/	
		133020	B. WIN			00/24/	2012
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ZIONSVI	LLE MEADOWS		675 S FORD RD ZIONSVILLE, IN 46077				
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	equipped with a	delayed egress lock					
	which was provi	ded with signage stating					
	the door could be	e opened in 15 seconds					
	by pushing on th	e door release device, but					
	the exit door did	not release within 15					
	seconds when the	e door was pushed with					
	the application o	f force five separate					
	times.						
	b. the exit doors	in the Moving Forward					
	Hall, A West Ha	ll, A East Hall, B Hall					
	and the Crystal I	Dining Room exit by the					
	service corridor	are each equipped with a					
	delayed egress lo	ock. Each exit door was					
	provided with sig	gnage stating the door					
	could be opened	in 15 seconds by pushing					
	on the door relea	se device except for the					
		loom exit by the service					
	corridor which w	vas not provided with the					
	signage. The Cr	ystal Dining Room exit					
	door did not have	e the access code posted					
	at the exit door b	out the exit door did					
	release when the	door was pushed with					
		f force for 15 seconds.					
		ew at the time of					
	observation, the	Assistant General					
	Manager stated t	he Crystal Dining Room					
	exit door by the	service corridor is a					
	-	oor and acknowledged					
	, ,	ot provided with signage					
		could be opened in 15					
	_	ing on the door release					
	device.	<u>C</u>					
	3.1-19(b)						
	<u> </u>						

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED			
		155620	A. BUILDING B. WING	- ·	08/24/2012			
NAME OF F	PROVIDER OR SUPPLIEI	R	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
				FORD RD				
	LLE MEADOWS		ZIONSVILLE, IN 46077					
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION			
TAG		R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155620			LDING	01	(X3) DATE (COMPL 08/24 /	ETED	
	ROVIDER OR SUPPLIER			675 S F	ADDRESS, CITY, STATE, ZIP CODE FORD RD VILLE, IN 46077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K0062 SS=C	continuously main condition and are periodically. 19 NFPA 25, 9.7.5 Based on observ facility failed to supply of spare sautomatic sprink with NFPA 25, 1 Standard for the Maintenance of Protection Systematics a supply sprinklers shall be the premises for The stock of spare proportionally reand temperature sprinklers. A min of each type and installed shall be practice could after and visitors if the be shut down because it available. Findings include Based on observ General Manage Assistant during	tic sprinkler systems are ntained in reliable operating inspected and tested 1.7.6, 4.6.12, NFPA 13, ation and interview, the provide a complete prinklers for the ler system in accordance 998 Edition, the Inspection, Testing, and Water-Based Fire ms. Section 2-4.1.4 of at least six spare be stored in a cabinet on replacement purposes. The sprinklers shall be presentative of the types ratings of the system nimum of two sprinklers temperature rating provided. This deficient fect all residents, staff the sprinkler system had to cause a proper sprinkler as a replacement.	K00	062	K062 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: New spare sprinkler heads have been ordered and are expected to arrive by 9/12/12. 2) How the facility will identify other residents having the potentiat to be affected by the same deficien practice and what corrective action will be taken: All residents have the potential to be affected. An inventory of all the types of sprinkle heads found within the facility was conducted and spares for all identified sprinkler heads were purchased. 3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Maintenance Director will ensure that facility always has two spare sprinkler heads for each type of sprinkler head that the facility utilizes. If facility must use one of	al ut er	09/21/2012

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AND PLAN OF CORRECTION IS5620 NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG Combined total of one sidewall spare sprinkler was located in spare sprinkler cabinets in the facility. Sidewall sprinkler heads were observed in the facility during the tour. Based on interview at the time of observation, the Assistant General Manager acknowledged only one sidewall sprinkler was located in the three spare sprinkler cabinets. 3.1-19(b) DI PREFIX TAG PROVIDERS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077 DATE DI PROVIDERS NEAD OF COMPLETION COMPLETION COMPLETION TAG COMP	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (Combined total of one sidewall spare sprinkler was located in spare sprinkler riser rooms in the facility. Sidewall sprinkler heads were observed in the facility during the tour. Based on interview at the time of observation, the Assistant General Manager acknowledged only one sidewall sprinkler was located in the three spare sprinkler cabinets. STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077 ID PROVIDERS PLAN OF CORRECTION (EACH OF ORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEPICIENCY) DATE	AND PLAN OF	FCORRECTION		A. BUILDING	01	
Combined total of one sidewall sprinkler was located in the facility. Sidewall sprinkler heads were observed in the facility during the tour. Based on interview at the time of observation, the Assistant General Manager acknowledged only one sidewall sprinkler was located in the three sprinkler cabinets. Complete to the sprinkler was located in the three spare sprinkler cabinets. Complete to the sprinkler than the sprinkler was located in the three spare sprinkler cabinets. Complete to the providers plan of correction (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPLETENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPLETENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPLETENCY) (COMPLETION DATE) TAG			155620			08/24/2012
	AND PLAN OF NAME OF PRO ZIONSVILL (X4) ID PREFIX TAG	SUMMARY S SUMMARY S (EACH DEFICIENT REGULATORY OR combined total of sprinkler was locabinets in the flint the facility. S were observed in tour. Based on it observation, the Manager acknow sprinkler was locabinets in the facility.	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) of one sidewall spare cated in spare sprinkler nree sprinkler riser rooms idewall sprinkler heads in the facility during the interview at the time of Assistant General wedged only one sidewall cated in the three spare	A. BUILDING B. WING STRE 675 ZIOI ID PREFIX	D1 S FORD RD NSVILLE, IN 46077 PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY) the backup sprinkler heads, Maintenance Director will place order for new replacement sprink head to be stored as back-up 4) How the corrective action(s) we be monitored to ensure the deficient practice will not recur, i what quality assurance program will be put into place. Administrator or designee will ensure that replacement sprinkler	COMPLETED 08/24/2012 (X5) COMPLETION DATE ler vill .e.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155620			LDING G	ONSTRUCTION 01	(X3) DATE COMPI 08/24	ETED	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
ZIONSV	ILLE MEADOWS		675 S FORD ZIONSVILLE,		-ORD RD VILLE, IN 46077		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF	BE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0064 SS=F	NFPA 101 LIFE SAFETY Corportable fire extinhealth care occu 9.7.4.1. 19.3.5 Based on observing facility failed to fire extinguisher month. NFPA I Fire Extinguisher requires fire extileast monthly wand the initials obeing recorded. Section 4-2.1 de "quick check" to extinguisher is a It is intended to the fire extingui operable, verify designated place or tampered with or physical dam prevent its operapractice could a any staff and vis Findings included Based on observing General Manage Assistant during 1:00 p.m. to 4:4	ODE STANDARD Inguishers are provided in all pancies in accordance with 6.6, NFPA 10 Vation and interview, the inspect 15 of 15 portable in the facility each 10, Standard for Portable ers, Section 4-3.4.2 Inguisher inspections at ith the date of inspection of the person performing. In addition, NFPA 10, effines inspection as a consure the fire exactly evaluable and will operate, give reasonable assurance sher is fully charged and ing that it is in its eq., it has not been actuated the and there is no obvious age or condition to action. This deficient effect 156 residents and sitors in the facility.	KOO		K064 1) What corrective action(s) will accomplished for those resident found to have been affected by deficient practice: All identified extinguishers were immediately checked and signed off on. 2) How the facility will identify other residents having the potent to be affected by the same deficient practice and what corrective act will be taken: All residents have potential to be affected. All fire extinguishers have been checked and documented on and will be checked monthly by facility Maintenance Director or designed. 3) What measures will be put in place or what systemic changes facility will make to ensure that deficient practice does not recur Facility Maintenance Director will ensure that all facility fire extinguishers will be checked monthly and documented 4) How the corrective action(s) be monitored to ensure the deficient practice will not recur,	the I fire Intial cient cion the I t	09/21/2012
					what quality assurance program		
	portable fire ext	inguisher located in the			at quanty assurance program	•	1

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	OF CORRECTION	IDENTIFICATION NUMBER: 155620	A. BUII B. WIN	LDING	01	COMPLI 08/24/	ETED
	PROVIDER OR SUPPLIER			675 S F	ADDRESS, CITY, STATE, ZIP CODE FORD RD VILLE, IN 46077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	(X5) COMPLETION DATE
	were not docume 2012. The follow extinguisher local monthly inspecting period of May 20 Room 319, by Roin the boiler room by the dock and I The following pollocations did not inspection docum Room 120, by the Room 217, outsing Room, by the Cottage 3 states Nurse's Station, I and for the K-Clakitchen. Based of the observations, Manager acknown inspections for policy.	on documented for the 2012 through July 2012: by 200m 331, by Room 303, in, in the elevator room 20 by the employee lounge. 20 ortable fire extinguisher 20 have a monthly 2012: by 20 e Activity Center, by 20 de the Crystal Dining 20 ortable 3 Riser Room, by 20 irs, by the Cottage 2 20 oy the Cottage 2 elevator 20 ass extinguisher in the 20 interview at the time of 20 ortable extinguishers 20 ortable 20 ortable extinguishers 20 ortable			will be put into place. Facility Administrator or designee will monitor fire extinguishers monthly for 4 months to ensure checks are being completed 5) By what date the systemic changes will be completed: Date of Completion; 8/27/12		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155620		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/24/2012		
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0144 SS=F	exercised under Imonth in accorda 3.4.4.1. 1. Based on record the facility failed written record of the starting batter generators was not weeks. Chapter requires storage connection with systems shall be not more than 7 maintained in full manufacturer's splatteries shall be immediately upon Furthermore, NF checking storage electrolyte levels than 7 days. Charequires a written performance, exercipairs for the generators for the generators and a having jurisdiction practice could aff and visitors. Findings include	spected weekly and pad for 30 minutes per new with NFPA 99. The description of the spectrum o	K01	44	K144 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Facility Maintenance Director will ensure that the following actions take place 1) weekly generator inspections are completed which will include inspecting the battery, 2) Monthly Load tests are completed and documented on the facility monthly generator load test form, and 3) Monthly load test includes the time it takes to transfer power from the generator. 2) How the facility will identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. Generator inspections will be completed per facilities preventative maintenance plan. 3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:	al tt	09/21/2012

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LDING	01	COMPLETED	
		155620	B. WIN			08/24/2012	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ORD RD		
ZIONSVI	LLE MEADOWS			ZIONS\	/ILLE, IN 46077		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	·	DATE	
		kly Exercise/Monthly			Facility Maintenance Director will record the weekly and monthly		
		and "Weekly Generator			generator tests in the facility		
		" documentation with the			generator book located in the		
		l Manager during record			maintenance shop.		
		15 a.m. to 11:50 a.m. on					
		y emergency generator			4) How the corrective action(s) wil	I	
		nspection records for the			be monitored to ensure the		
		d of 06/18/12 through			deficient practice will not recur, i.e		
	07/02/12 and 07/	16/12 through 08/13/12			what quality assurance program will be put into place. Facility		
	were not available for review. Based on				Administrator or designee will chec	k	
	interview at the time of record review, the				the generator book to ensure that		
	Assistant Genera	ıl Manager acknowledged			the above referenced changes are		
	weekly emergency generator battery				taking place each month.		
	inspection record	ds for the aforementioned			Administrator or designee will chec	k	
	weekly periods in 2012 were not available				the generator book monthly for 4		
	for review.				months.		
	3.1-19(b)						
	2. Based on reco	ord review and interview,					
		to ensure a monthly load					
	1	nergency generators was					
		of 12 months using one					
		wing methods: under					
		rature conditions, at not					
	less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading						
		•					
	that maintains the minimum exhaust gas						
	temperatures as recommended by the						
	manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators						
	_						
	_	gency electrical system to					
		with NFPA 110.					
	I Chapter 6-4.2 of	NFPA 110 requires				l	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155620		(X2) MULTIPLE (A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 08/24/2012			
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION		
	service to be exemonthly, for a nusing one of the a. Under operation or at not less that nameplate rating b. Loading that exhaust gas tem recommended b. The date and time testing shall be abased on facility 3-5.4.2 requires inspection, performed and repair maintained and by the authority deficient practice residents, staff at Findings included Based on a review Generator - Week Load Test Log" Inspection Sheek Assistant Generator of the service of the s	maintains the minimum peratures as y the manufacturer. ne of day for required decided by the owner, y operations. NFPA 99, a written record of ormance, exercising rs shall be regularly available for inspection having jurisdiction. This e could affect all and visitors. e: e: ew of "Emergency ekly Exercise/Monthly and "Weekly Generator t" documentation with the al Manager during record 15 a.m. to 11:50 a.m. on					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155620		A. BUI	LDING	NSTRUCTION 01	(X3) DATE COMPI 08/24/	ETED		
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS			B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE	
		t documentation for the nd May 2012 was not iew.						
	3.1-19(b)							
	the facility failed power would be emergency gener of building power NFPA 99, 3-4.1. shall have suffice the load and meet and voltage stable emergency system loss of normal porrequires a written performance, experience, experience in a wailable for inspection.	ord review and interview, at to ensure emergency transferred to 1 of 1 rators within 10 seconds er loss for 3 of 12 months. 1.8 states generator set(s) itent capacity to pick up et the minimum frequency ality requirements of the m within 10 seconds after ower. NFPA 99, 3-5.4.2 in record of inspection, ercising period and regularly maintained and rection by the authority on. This deficient affect all residents, staff						
	Findings include	:						
	Generator - Wee Load Test Log" : Inspection Sheet Assistant Genera	w of "Emergency kly Exercise/Monthly and "Weekly Generator " documentation with the al Manager during record 15 a.m. to 11:50 a.m. on ly load test						

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	OF CORRECTION IDENTIFICATION NUMBER: 155620	A. BUIL B. WINC	DING	<u>01</u>	COMPL 08/24/	ETED		
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE		
	documentation of emergency power transfer time for the period of May 2012 through July 2012 was not available for review. Based on interview at the time of record review, the Assistant General Manager acknowledged monthly load test documentation for emergency power transfer time for the period of May 2012 through July 2012 was not available for review. 3.1-19(b)							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI COMPLETI						
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155620		A. BUILDING O			08/24/2012			
		155020	B. WIN			00/24/	2012	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD				
ZIONSVILLE MEADOWS			ZIONSVILLE, IN 46077					
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE	
K0147	NFPA 101	LSC IDENTIF FING INFORMATION)		TAU	BELIEBRELI		DATE	
K0147 SS=D	LIFE SAFETY CO Electrical wiring a accordance with I Electrical Code. 9 Based on observe facility failed to cords including pused as a substitu NFPA 70, Articl specifically permetables shall not be fixed wiring of a	nd equipment is in NFPA 70, National	K01	47	K147 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Identified extension cords were removed immediately		09/21/2012	
	General Manage Assistant during 1:00 p.m. to 4:40 refrigerator and a plugged into a po Room 213. Base time of observati Assistant acknow a microwave over	ations with the Assistant r and the Maintenance a tour of the facility from 0 p.m. on 08/24/12, a microwave oven were ower strip in resident ed on interview at the on, the Maintenance wledged a refrigerator and en were plugged into a sident Room 213.			2) How the facility will identify other residents having the potentia to be affected by the same deficien practice and what corrective action will be taken: All residents have the potential to be affected. Facility Maintenance director and his staff will evaluate all resident rooms to ensure that there are no extension cords or power strips being used to power, refrigerators, microwaves, coffee pots, or medical equipment. Facility Maintenance staff will remove any of the power strips found in use in resident rooms. An audit of all resident rooms was conducted on 8/27/2012 and findings were corrected immediately.	t		

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155620		A. BUILDING B. WING	COMPLETED 08/24/2012				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Upon admission, all residents will be informed that they are not to use power strips or extension cords in their rooms. Management staff will include checking for power strips and extension cords on their weekly room rounds to ensure that all rooms are free of extension cords and power strips 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place. Facility administrator or designee will check documentation on room round sheets to ensure that facility is in compliance with this regulation.				

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